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**Report of Key Cost Drivers  
and Payment Mechanisms for  
the State of California Acute  
and Long Term Care  
Integration Program**

*Final Draft*

Contra Costa Health Plan  
County of San Diego

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- Summary of Medicare Sufficiency Study Results

# 1

## **Executive Summary**

### **Introduction and Background**

Contra Costa Health Plan (Contra Costa) and the County of San Diego (San Diego) (grantees) are working collaboratively with the California Department of Health Services, Office of Long Term Care toward implementation of an Acute and Long Term Care Integration program (ALTCI) for aged, blind, and disabled (ABD) Medi-Cal eligible adults. As part of this initiative both grantees contracted with Mercer Government Human Services Consulting (Mercer) to analyze and identify the primary cost drivers of the ALTCI population. This analysis along with other projections and other research will result in preliminary recommendations for the design of appropriate reimbursement mechanisms for the ALTCI program. In addition, analysis was performed to assess the general sufficiency of Medicare reimbursements for Medicare services for the ALTCI target population. This was done because the current ALTCI program design will require Medi-Cal contracted health plans to also be Medicare Advantage (MA) plans, to enable the integration of funding at the health plan level.

### **Methodology**

Mercer utilized historical Medi-Cal and Medicare fee-for-service (FFS) claims and eligibility data from 1998 through 2000 as the base data for our analysis. This data set has been used for other analyses in the past, and represented the most currently available and relatively complete data set applicable for this project. It is important to note that for actual capitation rate development purposes, the State of California (State) should use more recent claims data and information.

The historical claims data/expenditure experience was first filtered to reflect our understanding of the services and population groups that would be eligible for, and covered through, the ALTCI program. A complete discussion of the adjustments to the

data is included in the body of this report. The applicable data was then compiled in a variety of ways to begin to identify the most important cost drivers for this population.

The following hierarchy of groupings was utilized for the analysis:

- Total costs per member per month (PMPM);
- Costs by setting (i.e., nursing home or community);
- Costs by frailty (i.e., at risk of institutionalization, developmental disability (DD), or not at risk);
- Costs by dual eligible status (i.e., eligible for both Medi-Cal and Medicare or Medi-Cal only<sup>1</sup>); and
- Costs by category of aid (COA) (i.e., Aged or Disabled).

In addition to reviewing the data by the hierarchies above, average PMPM expenditures were compiled by chronic disease category. This analysis was done in order to determine whether average expenditures for members diagnosed with a variety of disease conditions should be used as a basis of payment for the ALTCI program. The historical data was also reviewed using the same disease groupings for high-cost cases (i.e., members whose annual Medi-Cal expenditures exceeded \$100,000).

Mercer also researched and summarized the reimbursement mechanisms employed by other state Medicaid programs that run integrated acute and long term care programs (Arizona, Massachusetts, New York, Minnesota, and Texas). Understanding the rational for the approach utilized in other programs is helpful in developing recommendation options for the State's ALTCI program.

For the Medicare Reimbursement Sufficiency Study the 2000 Medicare expenditures and claims detail was used as the base. This information was utilized to create estimated Medicare payment/reimbursement levels for the ALTCI population in 2000. The expenditures were then compared to the estimated Medicare revenues at different population group levels. This allowed for an historical assessment of the sufficiency of Medicare reimbursement for the ALTCI population.

## Findings and Conclusions

Variables impacting the payment mechanism include the program design of who will be eligible and what services will be covered. These same variables will also drive the potential risk differential that can be expected among contracted health plans. Likewise, the contracting approach and the number of enrollment options available to members will also be an important determinant to the potential variance in population risk among contracted health plans. In order to create the appropriate incentives for care management and service integration, reimbursement needs to be sufficiently sophisticated to promote

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<sup>1</sup> Medi-Cal only includes members with no Medicare and those with Part B coverage only.

program goals, especially in situations when multiple health plans will enroll the target populations and the ALT CI population will voluntarily enroll into health plans.

The cost driver analysis forms the basis of the rate structure recommendation. Setting of care (i.e., institutionalized vs. community-based members) was determined to be the primary cost driver for the ALT CI target population group. Frailty was the next most important cost driver (and therefore predictor of risk). Within each level of setting and frailty the dual eligible status becomes an important cost driver. Eligibility category (aged vs. disabled) is not a sufficient cost driver to be considered for a reimbursement model except for the “community not at risk” group, where there was a clear difference in average expenditures. Chronic disease conditions as cost drivers were found to be secondary to the factors above, except for the ventilator dependant members.

The high-cost case analysis showed that most outlier cases exist from more acute types of episodes or conditions that are not easily predicted by any of the identified cost drivers. Therefore, individual stop-loss (reinsurance) coverage may well be appropriate to match reimbursement to the risk of these outliers.

The introduction of a risk sharing arrangement that protects the state and health plans from unexpected profits and losses has proven successful in other managed long term care programs. The use of a temporary risk sharing arrangement demonstrates the state’s willingness to be a partner with the health plans and support the level of funding necessary to ensure that the health plans and provider networks remain viable financial partners.

Several incentives exist that have been implemented in other managed long term care programs to promote community based alternatives for the nursing home certifiable membership. Some incentives for consideration include the creation of an incentive payment for nursing home discharges and the development of performance targets, where a portion of the funding is dependent upon the health plan achieving published targets for community-based care.

The historical Medicare reimbursement sufficiency study yielded consistent results between the two counties, where the Medicare payment levels appear to be sufficient in total for both Contra Costa and San Diego, but are more or less than sufficient for different population subgroups. As a result of these findings, the excess Medicare funding in certain subgroups would enable Medi-Cal funding to be redistributed to other subgroups within the ALT CI program. We recommend updating this analysis, utilizing more recent data to ensure estimated Medicare funding will remain sufficient in the immediate future for the ALT CI population.

Case management is a critical component to the successful integration and utilization management of the integrated acute and long term care program. Strong case management has proven to improve the quality of care of the individual members and

increased efficiency; thereby reducing costs overall through more appropriate use of hospital, emergency room, and nursing home services. As such, increased case management should be supported and funded. However, the financial savings generated from some of the case management activities may not be readily observed in the initial years of the program.

The reimbursement model will have to reflect the appropriate costs for administration within the capitation rate, which will include case management and other assigned activities to the health plans. In order to appropriately assess this value, the State and the counties will have to determine which entity will perform each administrative responsibility and determine how funding for administration will be accomplished. Furthermore, in the initial years of the program, health plans will need to make a significant investment in their program; incurring additional start-up costs. To ensure sufficient plan participation, the State should focus on adequate reimbursement and health plan protections in the initial years of the program. The administrative costs as a percentage of total revenue will likely be higher in the initial years due to both start-up expenses and because the membership base will still be ramping up.

Based on the historical data reviewed, it appears that ALTCI may be feasible in San Diego and Contra Costa. In the case of San Diego, additional analysis of the Medicare reimbursement using more recent Medicare FFS claims experience would be advisable.

## **Recommendations**

The State will need to continue to demonstrate its partnership with the counties and health plans to ensure future success of ALTCI. Managed long term care programs across the country have successfully integrated acute and long term care, improving the quality of care through coordination and increased access to services. At the same time, long term savings has been achieved through a more flexible payment system that incents greater use of community based services. State's current handling demonstrates a willingness to approach this major change in the current system thoughtfully and with stakeholders input. Future success of ALTCI requires that the capitation funding mirror the program requirements and are focused in a way that supports program goals.

## 2

### **Overview of Managed Long Term Care Financing**

The goal in rate setting is to match the payment to the risk of the population enrolled. Most managed long term care programs currently in existence capitate their payments, providing a fixed prospective monthly payment for each enrolled member. There are many variables that require consideration when developing a payment mechanism that appropriately reimburses health plans for the risk of the population enrolled.

Depending on the complexity of the Managed Long Term Care model, payment mechanisms can be very simple with a single rate cell, or very complex with many rating categories. However, even with simplified reimbursement structures, the capitation rate development process is not simplified. It is still necessary to isolate, analyze, and account for major cost drivers in the development of capitation rates. These cost drivers are explored later in this report.

When developing the capitation rates and rate structure it is important to take into consideration the program and policy goals as well as the operational logistics under which the program will function. At the time of this analysis, many program and policy decisions had been made regarding ALTIC. However, many additional details remain to be determined, which could impact the analysis and conclusions contained in this report.

### **Enrollment and Assessment Process**

How will the enrollment process work? Who is responsible for approving eligibility? How often will eligibility be redetermined? Who will be responsible for the initial assessment and reassessment? Who will be assessed, everyone, or only those that would be considered nursing home certifiable (NHC)? Where there are multiple plans, in a mandatory county how will the auto-assignment algorithm work for members who do not select a plan on their own?

For purposes of the analysis, Mercer assumed the counties would continue to determine eligibility and the ALTCI plans would perform the assessments. Reassessments would occur on an annual basis for those members considered “at risk” and everyone would receive an initial screening/assessment.

## **Populations Covered**

What populations will be included in the ALTCI program? Children under age 18 or 21? DD? HIV/AIDS? Will there be any populations that will be allowed to opt out or enroll on a voluntary basis? Will passive enrollment be allowed?

Some Long Term Care (LTC) programs implemented in other states have been designed to specifically target a subset of the ABD population. The smaller the target population, the less risk differential will occur. Therefore, programs that enroll a broader spectrum of the entire ABD population will typically require a more complex rate structure or risk considerations.

For purposes of the analysis, Mercer assumed all Aged and Disabled populations over age 21 will be mandatory enrolled in an ALTCI health plan. To the extent that the enrollment is voluntary, the State would need to monitor the individual rates to minimize potential gaming of selection bias.

## **Services Covered**

What services will the health plans be responsible for providing? Will all behavioral health services be included or carved out? Will there be additional services paid for on a FFS basis? Will there be any limits on certain services (e.g., adult dental)? Will nursing home share of cost be paid outside of the capitation rate?

Programs implemented in other states have been designed to render certain services for the targeted population. The depth of services offered through the ABD managed care program can also influence the sensitivity of the risk attraction patterns. As such, the services offered in combination with the portion of the population enrolled should be considered when designing the reimbursement/rate structure and analyzing the risk considerations.

For this analysis we assumed the following exclusions: specialty mental health services and DD waiver services (i.e., regional center services). In addition, it was assumed there would be a limit on adult dental of \$1,000 annually. Mercer also eliminated 93 percent of pharmacy expenditures for the dual eligible population since it will not be a significant factor after January 1, 2006, due to Medicare Part D. Nursing home share of cost is excluded from the nursing home data.

## **Provider Network**

In cases where multiple health plans will be enrolling the target population, recipients are typically attracted to a particular plan based upon their marketing activities and/or their network of providers. As a result, risk variation is likely to occur when multiple health plans are offered in a given market. In order to avoid significant profits or losses due to recipient attraction patterns rather than effective management, several ABD programs have designed reimbursement mechanisms with multiple rate categories and/or specific risk adjustment provisions.

Similar to the multiple health plan consideration, multiple program options can also lead to differing recipient attraction patterns. As such, voluntary programs that offer both managed care and FFS delivery systems for the receipt of health care services can lead to risk differences between the programs and among the participating health plans. As a result, voluntary ABD programs have designed reimbursement mechanisms with multiple rate categories and/or specific risk adjustment provisions.

In San Diego, where the expectation is that there will be multiple health plans, the payment structure will need to adjust for the potential variation in risk of the population that is enrolled in each health plan. Allowing multiple health plans requires a more complex payment structure to ensure appropriate payment to each plan. If Contra Costa ends up with just a single contracted health plan, the risk of the variation in enrollment would be greatly minimized, allowing for a more simplified payment rate structure.

For purposes of our analysis and recommendations, we have assumed there will be multiple health plans. However, where there is a single contracting health plan, the rate structure could be simplified.

## **Integration with Medicare**

How will the program integrate with Medicare? How will the State explicitly address the overlap in services covered by both Medicare and Medicaid, such as nursing home and home health care? Is there an opportunity for savings based on the current Medicare reimbursement rates or will the plans likely be at risk of incurring an operating loss from the Medicare program?

With the recent introduction of the Medicare Modernization Act (MMA), there is greater opportunity for managed care plans to integrate the Medicare and Medicaid funding sources for the dual eligible members through MA special needs plans (SNPs). For purposes of this analysis it was assumed that the State will require all ALTCI plans to also be MA plans. Based on this model, the State should examine the adequacy of the Medicare reimbursement for each of the various rating categories. Adjustments to the Medi-Cal reimbursement may need to be made for certain rating categories if the funding on the Medicare side is inconsistent with the potential Medicare service risk for the dual

eligible population. Likewise, Medi-Cal funding may be able to be scaled back for other rating categories if the Medicare reimbursement is considered more than sufficient. The goal is to provide adequate funding for the combined Medicare and Medi-Cal services to ensure the appropriate reimbursement for each rating category and provide the proper incentives to further the policy goals of the program.

## **Case Management/Care Coordination**

What will be the requirements for the health plans regarding case management and care coordination? Will the State mandate a minimum number of hours per person or a minimum ratio of case managers to members? How will the State reflect these additional costs into the rate structure?

Case management is a critical component to the successful integration and utilization management of the integrated acute and long term care program. Strong case management has proven to improve the quality of care of the individual members and increase efficiencies, thereby reducing costs overall.

## **Administration**

Who will have primary responsibility for each of the various administrative functions required to implement and maintain a managed long term care program?

The reimbursement model will have to reflect the appropriate costs for administration within the capitation rate. For example, if the health plan is responsible for performing the assessment, and that assessment is to be performed annually, then the administrative costs for performing that assessment will need to be added to the capitation rate.

Administrative functions typically provided by health plans include, but are not limited to:

- claims processing,
- provider network development and monitoring,
- member services,
- quality management and quality assurance activities,
- utilization review and management,
- grievance and appeals processing,
- information system support,
- cultural competency,
- general administration, and
- marketing.

In addition, the State and the counties will have to determine who will need to perform the remaining administrative responsibilities and how funding for administration will be accomplished.

Furthermore, in the initial years of the program, health plans will need to make a significant investment in their program; incurring additional start-up costs. As a policy goal, and to ensure sufficient plan participation, the State may reward plans to be more focused on the initial years of the program. The administrative costs as a percentage of total revenue will likely be higher in the initial years due to both start-up expenses and because the membership base will still be ramping up.

# 3

## **Case Studies of Various States**

The following provides a discussion of the various key considerations from the previous sections, as it applies to specific states, along with any unique features and financing details. We have selected five states that represent a variety of managed long term care programs.

The states provided in the case studies include:

- Arizona,
- Massachusetts,
- New York,
- Minnesota, and
- Texas.

Additional detail regarding the program design and payment structures of the states provided in the case studies along with some additional states including New Mexico, New Jersey, and Pennsylvania can be found in Appendix 1.

### **Arizona Long Term Care System (ALTCS)**

Arizona has utilized a mandatory managed care program, ALTCS, to achieve an integrated acute and long-term care approach to service delivery since 1989. The ALTCS program is administered by a single state agency, Arizona Health Care Cost Containment System (AHCCCS), and includes members of the ABD eligibility groups that have been determined to be “at-risk” of institutionalization. This determination of “at-risk” status is performed by Arizona State eligibility staff. All other ABD members eligible for AHCCCS (i.e., those that have not been determined to be at risk of institutionalization) are enrolled in AHCCCS’ contracted acute care Managed Care Organizations (MCOs). Although it is not currently a requirement for ALTCS contractors to also participate in the

MA program, some plans are moving in that direction. In fact, some of these plans will be operational MA plans prior to January of 2006.

The ALTCS program has very few service or population group exclusions. All AHCCCS covered services are available through the ALTCS contracted health plans, with the exception of certain services for children with special health care needs. While these children are still enrolled with a contracted ALTCS plan for all other services, they receive services to treat their qualifying condition through Arizona's Children's Rehabilitative Services (CRS) program. All other services such as behavioral health, case management, and long-term support services (e.g., personal care) are included in the ALTCS program. All subgroups of the "at-risk" ABD population are enrolled with the ALTCS plans, regardless of age or dual eligibility status. The only population carve-out for the program relates to the DD group. However, DD members are still required to enroll with an ALTCS plan; AHCCCS just contracts with a single ALTCS plan to serve all DD eligible members statewide.

In 2001, AHCCCS began offering members a choice of multiple ALTCS plans in one of Arizona's 15 counties, Maricopa County. The other counties are served by a single ALTCS plan and the statewide DD ALTCS plan. Therefore, in all but one county all ALTCS risk is concentrated with a single ALTCS plan. This has enabled AHCCCS to utilize what initially appears to be a simplified capitation model. However, upon closer examination, the total reimbursement approach utilized by AHCCCS, including the actual rate development process, has proven to be sufficiently sensitive to appropriately reimburse their contracted ALTCS plans by matching reimbursement to risk.

The reimbursement approach involves a single capitation rate that applies to 99 percent of the ALTCS members in a given county, regardless of their home and community based service (HCBS) vs. institutional service setting. A separate capitation rate is developed and applied to certain ALTCS eligible members who are ventilator dependent (for a minimum number of hours per day). These are the only capitation rates paid for the ALTCS members. In addition to the capitation rates though, AHCCCS employs additional mechanisms to essentially risk-adjust payments to the ALTCS plans.

- AHCCCS provides a monthly supplemental payment to its contracted health plans for members with HIV/AIDS.
- AHCCCS utilizes a reinsurance program with annual individual member thresholds for hospital inpatient expenditures to address general acute episode experience. In addition, a catastrophic reinsurance program exists to address members who require major organ transplants and those that are diagnosed with hemophilia and gauchers. This catastrophic program has no expense threshold and a higher coinsurance (state participation) rate. Finally, Arizona also provides a measure of stop-loss coverage for members who suffer from Traumatic Brain Injury (TBI) when their annual expenditures exceed preset limits.

- AHCCCS also reconciles each ALTCS plan's actual HCBS vs. Institutional mix of members. The HCBS reconciliation utilizes a risk-corridor approach, so that the actual mix must be a certain percentage below or above the target used in the capitation rate development for that contracted plan, before it results in any recoupment or payment of additional funds by Arizona. This reconciliation process is utilized to provide protection to the plans for any extraordinary HCBS mix issues, while still incentivizing them to increase the percentage of members they serve in the community. AHCCCS sets the "target" HCBS mix for each contracted plan, in each county annually. This has allowed AHCCCS to encourage development of more HCBS resources, by setting the target beyond the current mix.
- The capitation rate development process itself is also very thorough, identifying, analyzing, and incorporating the primary risk drivers for the ALTCS population. This includes an analysis of dual eligibility status for the members enrolled with a contracted plan as well as the age and gender distribution of plan membership. Separate capitation rate sub-components are developed for three separate population groups (members receiving services in their own home, those receiving services in an alternative residential setting, and those living in a nursing home). These three separate rates and their many sub-components are weighted together based on expected member mix to calculate a single capitation rate.

AHCCCS has in part utilized their reimbursement model to be able to achieve steady and continual growth in the percentage of their at-risk members who are served in their home or other community-based setting. This HCBS penetration rate began at about 5 percent in 1989 and as of 2005 has climbed to approximately 60 percent. Their single rate approach has proven successful for their program with the supports of the other risk adjustment mechanisms employed. The success of this particular approach works in Arizona due in part to their single-plan contracting. It is not yet clear whether this reimbursement approach will continue to work in areas with multiple ALTCS health plans.

## **Massachusetts Senior Care Options**

In April, 2004, Massachusetts implemented an integrated acute, behavioral health and long term care program for its low income elderly population. The program covers all eligible members, age 65 and older, regardless of level of need. The program is voluntary and operates on a statewide basis. Currently, there are three health plans under contract. The participating health plans, called Senior Care Organizations (SCO), provide the full range of Medicare and Medicaid benefits to beneficiaries who voluntarily enroll.

SCOs are financed by the pooling of Medicare and Medicaid revenues at the health plan level. When a beneficiary enrolls in a SCO, he or she waives his or her right to Medicare freedom-of-choice, and agrees to receive all Medicare-funded services through the SCO in addition to the Medicaid services.

SCOs receive separate capitation payments from Medicare and Medicaid, and are reimbursed by Medicaid based on the following four major variables.

- region—Boston/Greater Boston and Rest of State;
- frailty status—Community Well, Alzheimer/Dementia, Chronic Mental Illness, or Nursing Home Certifiable;
- dual status—Duals and Non-Duals; and
- care setting—Community, Nursing Home Level 1, Nursing Home Level 2, and Nursing Home Level 3.

Each beneficiary is assigned a capitation rate base on these factors. In 2004, the rates ranged from \$300 PMPM for a community-dwelling beneficiary with few health care and support needs to \$9,000 PMPM for persons with profound disabilities living in a nursing facility. To encourage health plan support for community based services and minimize any unnecessary institutionalization, an incentive payment is built into the capitation rate based on the care setting. The capitation rate increases from a community rate to a nursing facility rate only, after three months of residency in a nursing facility. In contrast, the health plan is paid a nursing facility rate for three months after a person moves into the community from a nursing home, providing more money to assist with transition costs.

Since the Massachusetts SCO program is new and voluntary, there is an additional layer of protection built in to the program that protects the health plans and the state. Massachusetts designed a risk sharing program that will be in effect for the first three years of the SCO program. The state and the MCO share Medicaid losses or savings accordingly on a pro-rated basis. If the MCO operates (medical and administrative expenditures) within 5 percent of the capitation revenue, the MCO retains all of the savings or absorbs the loss. However, if the actual expenses are between 5 percent and 25 percent greater or less than the capitation revenue, the state and the MCO share the gain or loss. If expenditures are over 25 percent greater or 25 percent less than the capitation revenues, the MCO is responsible.

Creating the proper incentives to promote community based alternatives for the nursing home certifiable membership along with the early risk sharing program helps to promote the policy and financial goals of the state. At the same time the health plans are protected from the possible adverse risk associated with an unknown enrolled population. The program is now in its second year of operation. However, it is still too early to assess the effectiveness of the financing structure as to whether it is truly creating the proper incentives to promote the state's goal of increasing community based long term care, and minimizing unnecessary institutionalization of the frail elderly population. The financing mechanisms have been successful in attracting the necessary health plans and provider networks by demonstrating the state's willingness to be a partner with the health plans and support the level of funding necessary to ensure that the health plans and provider networks remain viable financial partners.

## **New York Managed Long Term Care Plan**

New York has operated a managed long term care plan for its elderly and physically disabled population for over a decade. The managed long term care (MLTC) model grew out of the state's early interest in integrated care and the use of the Program for All-Inclusive Care for the Elderly (PACE) model. In addition to its PACE program, New York operates a partially capitated model that covers primarily long term care services. Most of the acute care services are carved out and paid on a FFS basis.

Enrollment in MLTC is voluntary. There are 9 partially capitated health plans across the state covering over 10,000 enrollees. Enrollment ranges between 70 members in some plans to over 3,400 members. Enrollees must be Medicaid eligible and require a nursing home level of care. However, at initial enrollment, the member cannot reside in a nursing facility. Plans can choose to serve a population 21 and over, or 65 and over; most choose the latter.

New York has no limits on nursing facility care for MLTC plan enrollees. In New York, participants may continue to be enrolled in the MLTC program even after they enter a nursing facility. Currently, about 7 percent of enrollees reside in nursing facilities. This ranges between 0 percent and 21 percent depending on the health plan.

The MLTC program is capitated by Medicaid. Health plans are not required to be Medicare risk contractors, and currently none have such a designation. MLTC plans are reimbursed by Medicaid based on just two payment variables:

- region (four regions defined by county groups), and
- age (21-64 and 65+).

Because the health plans are responsible primarily for long term care services, there is not a significant distinction of costs between those members who are dually eligible and those who are only eligible for Medicaid. Therefore, there is not a separate payment rate for duals and non-duals.

In addition, the state pays a single rate, regardless of whether a member resides in the nursing home or in the community. The payment rates are subject to the actuarial soundness test under the Centers for Medicare and Medicaid Services (CMS) managed care regulations and are required to fall within a predetermined actuarially sound payment range. The capitation rates are negotiated annually with each health plan and are largely based on health plan reported financial information that is collected and reviewed by the state. The state also collects member survey information from each health plan that contains various frailty indicators including the number and types of activities of daily living limitations and disease categories. Payment rates vary significantly depending on the region and the level of frailty of the enrolled population.

## Minnesota Senior Health Options and Disability Health Options

Minnesota's Senior Health Options (MSHO) and Disability Health Options (MnDHO) programs combine Medicaid and Medicare funding to provide an array of primary, acute, and LTC services into one seamless package. MSHO was developed in 1997, and MnDHO was modeled from its predecessor and began enrolling adults with disabilities in 2001. Minnesotans 65 and over are required to enroll in Medicaid managed care on the acute side, but enrollment in the integrated MSHO and MnDHO programs is voluntary.

MSHO enrollees must be over the age of 65 and require a nursing home level of care. Both Medicaid-only and dually eligible recipients are eligible for the MSHO program. MnDHO currently serves people between the ages of 18 and 64 with physical disabilities. Like MSHO, these enrollees consist of both Medicaid eligibles and dual eligibles.

Initially, MSHO operated under a Section 1115 Medicaid waiver and a Section 402/222 Medicare waiver. In 2001, the state changed to a 1915(a)/(c) combination on the Medicaid side, but retained the 402/222 on the Medicare side, allowing them to continue operating using a modified Medicare payment methodology. The Section 402/222 waiver will no longer be required since the state will be transitioning Medicare health plan services to a SNP status under Medicare Advantage. Health plans in Minnesota that offer both a Medicaid managed care and a Medicare managed care plan to their beneficiaries can combine both capitation rates at the plan level.

In MSHO, the payment design aligns financial incentives between Medicare and Medicaid in order to reduce institutional placements and encourage use of home and community based services. Medicare and Medicaid payments are capitated. CMS makes Medicare payments directly to the health plans, and health plans receive Medicaid capitation payments from the state. The MSHO capitation structure has the following rating categories:

- Community Non-NHC: Enrollees who, at the time of enrollment in the MCO, are in a community living arrangement and have not been assessed to require a Nursing Facility Level of Care.
- Community NHC: Enrollees who, at the time of enrollment in the MCO, are enrolled in the Elderly Waiver program, and are in a community living arrangement.
- Institutionalized: Enrollees who, at the time of enrollment in the MCO, are in an Institutionalized living arrangement.
- Hospice: The following Rate Cell Categories will be assigned when an individual elects hospice:
  - Community Non-NHC Hospice: Indicates a Community Non-NHC Enrollee who has elected hospice.
  - Community NHC Hospice: Indicates a Community NHC Enrollee who has elected hospice.
  - Institutional Hospice: will be assigned to Institutionalized enrollees electing hospice.

For seniors who meet nursing home criteria but live in the community, the Medicare waivers provide a risk adjustment (the same as that for PACE programs—2.39 times the county Medicare rate) to the regular Medicare managed care payments. This is significant because it provides Medicare funding to reflect the higher level of services used by frail enrollees who reside in the community, thus providing a better financial incentive to the health plan to keep the person out of the nursing home. Medicare payments for other enrollees (people in nursing homes and the community non-frail) are the same as for other MA plans.

The MnDHO rating structure builds on the MSHO payment model for both Medicaid and Medicare, with broad rate cells for:

- Nursing Facility Residents: Enrollees living in nursing facilities;
- NHC—Conversions: Enrollees previously residing in nursing facilities who are moved into the community setting while enrolled in MnDHO;
- NHC—Diversions: Enrollees who are residing in the community but are at risk of locating into a nursing home; and
- Community: Residents who are not nursing home certifiable.

The above NHC categories are further subdivided into experience-based rate cells, reflecting waiver service eligibility or home care eligibility. Acute care costs are averaged within each rate cell. There are a total of 20 rate cell categories, which are then adjusted for Medicare eligibility and county of residence (Hennepin or other metro).

In the future, in order to account for variable risk on Medicaid acute care expenses, the state plans to use the Disability Payment System (DPS) to calculate an aggregate plan-specific risk adjustment factor for Medicaid acute care costs only. The rates will not be risk-adjusted prospectively. Instead, the plan will receive a health plan risk adjustment each quarter based on the plan's previous twelve-month claims experience. All rate cells are discounted at 4 percent, except for the value of the 180-day nursing facility liability.

Health plans may purchase stop-loss reinsurance on total per-person costs exceeding designated thresholds within a contract year. The cost of this reinsurance coverage is deducted from the rates for health plans that choose to purchase this coverage. In addition, Minnesota is offering risk sharing up to the value of 1.5 percent of the rates base, based on the health plan's actual enrollment mix for the first two years of the project.

Program administrators have reported high levels of satisfaction with MSHO and MnDHO. The managed LTC environment has successfully matched enrollees with needed services and has been particularly effective with ethnically diverse populations. The state reports low disenrollment rates (less than 3 percent) and high consumer satisfaction. Starting in June 2005, Minnesota is phasing in LTC services to their

mandatory acute care program for seniors in 20 counties. The new program, Minnesota Senior Care Plus, will operate under a 1915(b)/(c) combination waiver. MSHO will remain a voluntary alternative.

## **Texas Star+Plus**

Star+Plus, Texas's Medicaid managed LTC pilot program, began in April 1998. The program operates in Harris County (Houston) and serves SSI and SSI-related recipients who are seniors with physical or mental disabilities. The program operates under a combination 1915(b)/(c) waiver, which allows the State to provide home and community based services in a mandatory managed care environment. About half of the enrollees are Medicare/Medicaid dual eligibles.

A main goal of Texas when it began its managed LTC program was to provide better services to its aged and disabled population and reduce expenditures. Star+Plus integrates acute and LTC service delivery for its recipients to ensure coordination between services. One major advantage of Star+Plus is that if members are in need of nursing facility services, they can enroll in the Community Based Alternatives waiver without being placed on a waiting list, providing for timely services. The program also provides incentives for dual eligibles to enroll in the same MA plan as their Medicaid MCO to facilitate coordination with Medicare services. One of these incentives is that dual eligibles have unlimited access to medically-necessary prescriptions if they participate in a Medicare managed care product operated by the same MCO as their Medicaid plan. In the FFS program, their prescriptions are limited to three per month.

Star+Plus program manager's report that the program is successful. The program has been able to expand the number of people receiving LTC services while saving the state money. Texas Star+Plus, like Arizona's LTC managed care program, has increased the number of services provided in the community. Since implementation of Star+Plus, there has been a 70 percent increase in the number of clients using personal assistance services in the Star+Plus service area (Harris County) over a three year period (2001 to 2004). Currently, Texas is considering expanding the Star+Plus pilot to other parts of the state.

HMOs are capitated for STAR+PLUS on a PMPM basis by client risk group. There are three different risk groups based on setting, with amounts differing by Medicare status, for a total of six rate cells. Rates for Medicaid Only clients are higher than those for Dual Eligibles to reflect MCO liability for acute care. STAR+PLUS capitation rates are discounted 5 percent from projected FFS acute and community care costs. The three risk groups are as follows:

- Community Clients: A blended rate based on historical costs and projected utilization and expenditure data, for clients who are neither institutionalized nor enrolled in the Community Based Alternatives waiver at implementation. MCOs are liable for 120 days of nursing facility care for clients in this risk group. This rate covers clients who currently receive acute care services through Medicare as well as those who receive

- Medicaid long-term care services at home or in a community setting. For clients receiving only acute care, the capitation functions as long-term care insurance.
- CBA Waiver Clients: A rate for clients receiving services through the Community Based Alternatives waiver.
  - Nursing Facility Clients: A rate for clients who need nursing facility care. MCOs are liable for 120 days of nursing facility care. The rate payable is the same as the Community Rate.

Star+Plus carves-out services for persons with developmental disabilities into a separate 1915(c) waiver. The state also carves-out nursing facility services because of the complexity of billing (these services were initially included, but later carved-out).

HMOs participating in the Star+Plus program also participate in a profit sharing arrangement with the state. This is a graduated rebate method based on percent of profit against revenues. The higher the HMOs profit, the greater the percentage share of the state.

# 4

## **Data and Assumptions**

Prior to selecting a reimbursement methodology, key cost drivers need to be identified. To the extent that these cost drivers are predictive of future health care and support service costs, are readily identifiable within existing data sources, and occur in sufficient volume to warrant consideration can only be determined by evaluating historical experience associated with the target population in question. As such, historical demographic, diagnostic, and Medi-Cal payment information was collected for the ALTCI target population (ABD adults) in San Diego, and Contra Costa counties.

Prior to the proposed ALTCI program, recipients could receive traditional health care services from Medi-Cal and support services through the In-Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), and DD programs. Because these services are rendered by various departments, the capture of service utilization data has been complicated. Several years ago the Office of Long Term Care in partnership with the University of California, Los Angeles collected data from all departments to develop a single data repository. This data repository, referred to as the Linked data set, contained data with services that were rendered in calendar year 1998 through 2000. While dated, the Linked data set contained nearly all of the costs associated with the services in the long term care continuum and contained consistent relationships within the three observed years.

Before using the Linked data set for the cost driver analysis, several modifications were made to the data. These modifications include data exclusions to reflect only future ALTCI-applicable expenditures, adjustments to reflect actual payment levels, and prospective considerations to reflect future levels.

## Data Exclusions

The ALTCI program will enroll adults in the ABD categories of aid. To mimic the population to be enrolled, children (less than age 21) were removed from the base data. Similarly, any non-ABD experience was excluded. A complete listing of the beneficiary aid codes included within the cost driver analysis are listed in Appendix 2.

The ALTCI program will cover all acute and most long term care services. Services that are rendered through the DD waiver program will continue to be provided on a FFS basis. The costs and utilization associated with the DD waiver services were never captured within the Linked data set and as such, no explicit exclusion was required to remove the DD waiver services from the cost driver analysis.

Specialty mental health services will be provided outside of the ALTCI program. To the extent these services were identifiable within the Linked data, the specialty mental health services were excluded from the Linked data set. Most of the specialty mental health services were not originally captured within the Linked dataset since these costs are administered outside of the State's MMIS system. As such, these services were indirectly excluded from the cost driver analysis. Where cost and utilization associated with outpatient mental health clinics existed within the Linked dataset, their experience was explicitly removed from the cost driver analysis.

A complete listing of the services included in the Cost Driver analysis is contained within the Attachment B reports.

## Data Adjustments

The Linked data set is comprised of Medi-Cal and Medicare paid claims. If any cost settlements or recoveries are made in arrears, they are not reflected within the Linked data set. One such example is pharmacy rebates. Due to the CMS best pricing rule, pharmaceutical companies are obligated to charge Medicaid the best price offered to commercial entities. Similarly the State has negotiated discounts above those required by CMS, referred to as the State Sidebar Agreement. The value of these discounts is often not known until well after the provision of the pharmaceuticals. Therefore, the pharmacy rebates and Sidebar Agreement payments are made by the pharmaceutical companies in arrears. To reflect the impact of the national pharmacy rebates and the State Sidebar Agreement, the Medi-Cal pharmacy expenditures within the cost driver analysis has been reduced by 24.3 percent.

The Linked data set also includes IHSS authorized hours and payments. Since actual payments and incurred hours may vary from the authorized amounts, conversion factors were developed from summary-level data provided by the Contra Costa IHSS Public Authority and the San Diego Aging & Independence. The cost driver analysis was performed using 2000 IHSS data that was ultimately converted to a paid basis using a factor of 99.0 percent for Contra Costa and 88.7 percent for San Diego. More recent data

suggests these historical authorized-to-paid ratios have changed. Such changes have been accounted for in the development of trend factors applied to the applicable categories of service.

## **Medi-Cal Projections**

In order to assess the variation of risk inherent within the targeted ALTCI population, the Medi-Cal Calendar Year (CY) 2000 data was projected to CY 2007—the expected implementation year of the ALTCI program. These projections included any significant known program changes that occurred, or will occur, between the base data period and 2007. However, Mercer did not have access to the universe of program changes that have been implemented. For a complete listing of the program changes that were incorporated, please reference Appendix 3. One such policy change is the anticipated implementation of the Medicare Part D, where Medi-Cal will only be responsible for a minor portion of the pharmacy benefit (primarily over the counter medications and a few specialty drugs) for recipients with both Medicare and Medi-Cal coverage (dual eligibles). To reflect this upcoming program change in the analysis, pharmacy expenditures for dual eligibles have been reduced by 93 percent. While the Medicare Part D coverage is fairly comprehensive, some pharmaceuticals will remain Medi-Cal's responsibility.

In addition to policy changes, utilization and unit cost trends were used to project the data to CY 2007. To the extent possible, State specific trend information was used to develop the CY 2007 projections. The trends and the CY 2007 projection values are provided within Attachment B.

## **Medicare Data Exclusions and Adjustments**

The ALTCI program will enroll adults in the ABD categories of aid. To mimic the population to be enrolled, children (less than age 21) were removed from the base data. Similarly, any non-ABD experience was excluded. A complete listing of the beneficiary aid codes included within the cost driver analysis can be found in Appendix 2.

The population evaluated in the Medicare sufficiency study was further refined to include only those recipients with both Medicare Part A and Part B coverage. This population contained the requisite diagnostic information necessary to determine the recipient's health risk as measured within the most recent (CY 2005) reimbursement policies.

Medicare at risk health plans are not responsible for the costs associated with hospice services. As such, the Medicare expenditures used in the sufficiency study excluded the costs incurred for hospice.

No adjustment was made to reflect the expected pharmaceutical levels due to Part D implementation because Part D risk sharing provisions limit health plan exposure to significant gains or losses as a result of the addition of Part D benefits. Therefore, the

Medicare payment sufficiency analysis was performed on traditional Medicare benefits (Part A and Part B) only.

Attachment D contains the CY 2000 Medicare reimbursement sufficiency data.

# 5

## **Key Cost Drivers in ALTCI — Findings**

Experience in other managed care programs for long term care recipients indicates that several population characteristics can result in risk variation. In order to measure the possible risk variation within the ALTCI population, the following population characteristics were evaluated using the historical CY 2000 expenditures projected to CY 2007:

- Setting (Nursing Home or Community),
- Frailty (At Risk, DD, or Not at Risk),
- Medicare Status (Dual Eligible or Medi-Cal only<sup>2</sup>),
- Eligibility Category (Aged or Disabled), and
- Chronic Disease Conditions.

### **Setting (Nursing Home and Community)**

Receiving services in a nursing home setting is not only indicative that long term care services will be used, but also indicates the frailty, because the recipient is considered nursing home certifiable. Members living in a community however, have varying levels of need. The Chart 1.1 and Chart 1.2 contained in Attachment A illustrate the member months and payment distributions respectively by setting. Using the historical CY 2000 data presented in Attachment A, significant variation was observed between the recipients living in a nursing home versus those remaining in the community.

### **Frailty (At Risk, DD, and Not at Risk)**

Recipients at risk of nursing home admission often utilize personal care, home health, adult day health care, and waiver services that allow them to remain within the

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<sup>2</sup> Medi-Cal only includes members with no Medicare and those with Part B coverage only.

community. As such, recipient frailty is often used to determine the need for these LTC support services. There is not currently a method for determining frailty for the universe of potential ALTCI members. However, eligibility for the MSSP, IHSS, and other waiver programs require a determination of need for additional support services, which can be used as a proxy for at risk of institutionalization. While the MSSP, IHSS, and other waiver programs are indicative of the need for support services to avoid institutionalization, DD programs allow access to a distinctive set of services that were specifically designed for the needs of the DD population. As such, the DD population has been maintained as a distinctive population within the cost driver analysis. Charts 2.1 and 2.2 in Attachment A illustrate the member months and payment distributions respectively by frailty proxy. Using the historical CY 2000 data presented in Attachment A, significant variation was observed between the DD subpopulation, the members utilizing the various home and community based programs (at risk), and those members only receiving acute care (not at risk).

For the cost driver analysis, a frailty proxy was developed using recipient eligibility for support services through the MSSP, IHSS, and other waiver programs. If the State develops a uniform assessment tool, this tool may be used to better classify various risk characteristics and to determine additional cost drivers (such as assessment score or activities of daily living limitations.) However, the data to assess the implications on the rate structure would not be available for service years after the tool is implemented.

## **Medicare Status**

The cost driver analysis focuses on the risk from a Medi-Cal perspective. To the extent that another payor bears responsibility for some of the services, this reduces the Medi-Cal risk. When a recipient has dual coverage with both Medicare and Medi-Cal, and Medicare is responsible for most of the acute care services, this significantly reduces the risk to Medi-Cal. The degree of Medicare's financial responsibility is dependent on the type of coverage. For recipients that are only eligible for Part B services, which is comprised of the less costly services, these recipients have risk patterns that are more consistent with Medi-Cal only recipients. As such, the Part B only dual eligibles have been combined with the Medi-Cal only recipients. Charts 3.1 and 3.2 in Attachment A illustrate the member months and payment distributions respectively by Medicare Status. Using the CY 2000 data, significant variation was observed between the dual eligibles and non dual eligible recipients.

## **Category of Aid (Beneficiary Aid Code)**

Individuals can be eligible for ALTCI based on their age (65 years or older) or due to their disability status. The rationale for ALTCI eligibility can alone be an indicator of risk. Charts 4.1 and 4.2 in Attachment A illustrate the member months and payment distribution respectively by category of aid. Using the historical CY 2000 data, some variation was observed between the Aged and the Disabled. However, category of aid alone was not a major cost driver when controlled for setting, frailty, and Medicare status.

## **Disease Conditions**

The incidence of chronic disease conditions can significantly increase risk for acute care services, but is not typically the primary cost driver for nursing home recipients. When evaluating the PMPM costs by chronic condition, sufficient membership was necessary to produce reliable findings. In an effort to enhance the reliability of the results, the PMPM costs by chronic condition were based on the combined experience from three counties: Alameda, Contra Costa, and San Diego. The Alameda data was originally captured to possibly supplement the Contra Costa experience because it was geographically close and contained similar population characteristics. With other population characteristics, each county's information was able to support the conclusions. Given the sheer number of chronic conditions being evaluated, data from all three counties and all three years (CY 1998, CY 1999, and CY 2000) combined was required for the chronic disease condition assessment. The results of this analysis are provided within Appendix 4.

In order to receive special consideration in reimbursement strategy, average cost variation of a particular chronic condition should be significantly higher to warrant the creation of a separate rate cell. One condition that appears to meet this requirement is the ventilator dependent population. While the ventilator dependent population is relatively small, they represent over 20 percent of the cases presented that have Medi-Cal expenditures that exceed \$100,000 annually. As such, the State may want to consider a separate rate for the ventilator dependent population that is targeted to those high cost recipients. Developing a specific criterion for a targeted ventilator dependent population would require a more comprehensive data set than was available for study for the cost driver analysis. As a result, the county specific exhibits do not contain figures for a separate ventilator dependent rate.

## **In Combination**

While each of the above characteristics were observed independently to explain risk differential, when used in combination some of these subgroups become very small and are not considered credible numbers. For example, when controlled for Setting, Frailty, and Medicare Status, category of aid was not a major cost driver. As a result, for those populations using nursing home services or those at risk of nursing home services, a split between Aged and Disabled Eligibility Category is not necessary. However, for the population residing in the Community that is not at risk of institutionalization, Category of aid is a major cost driver. This is illustrated in Attachment C where the shaded boxes indicate the proposed rate structure.

Attachment B contains both the CY 2000 experience and the CY 2007 projections for the proposed rate structure by service.

## 6

### **Program Savings and Incentive Strategies**

As mentioned earlier in this report the program payment structure should be set up in such a way as to allow the State to meet its program and policy goals. Generally, managed long term care program goals are designed to support and encourage more appropriate use of community based services, increase case management and reduce unnecessary utilization of more costly institutionalizations. As a result, the financial savings generated from these policy goals may not be readily observed in the initial years of the program. Immediate efficiencies may be achieved from better management of acute care services. However, since these services represent between 35 percent and 40 percent of the total Medi-Cal costs, the potential savings to Medi-Cal exists, but is not as great when taken in combination with the potential savings from improved use of community based services. Additional savings accrue to Medicare, which in turn benefits the health plan if the health plan is reimbursed on a capitated basis by Medicare. Therefore, the State should consider the potential Medicare payment and costs to the health plans when determining the Medicaid capitation payment. As such, a Medicare sufficiency study was performed, the methodology applied and the results are presented in Section 7 of this report.

In addition to the immediate savings on the acute care services, there is additional opportunity for savings on a more long term basis. This is possible as more of the population shifts away from Nursing Home use into Home and Community Based alternatives. Savings due to these changes will not be apparent immediately, but will be more evident as ALTCI grows and matures. Savings in Arizona's Long Term Care program have been estimated at 16 percent per year primarily due to the shift in utilization toward Home and Community Based alternatives. Based on the 2000 historical data available for this study, the cost difference between members in the nursing home and those who are MSSP eligible is \$1,289 on a PMPM basis. This implies that the State could achieve a possible savings of \$1,289 PMPM on average for every month a person

stays in the community. Even when adding in additional costs for case management and other admin expenses, the potential savings are significant.

In order to achieve program goals and achieve some desired savings, states have implemented various payment strategies. These strategies include:

- payment of a single blended rate as in Arizona's ALTCS program with an adjustment each year to reduce the Nursing Home proportion of the payment rate;
- percentage off FFS equivalent cost;
- incentives to encourage use of HCBS services and delay or avoid Nursing Home use (e.g., Massachusetts SCO transitional period);
- incentive payment if discharged from the Nursing Home back to community as in Minnesota;
- apply savings from Medicare to Medicaid; and
- performance targets.

The advantages and disadvantages to each strategy are discussed below.

Payment of a single blended rate allows for a much more simplified payment structure. It is easy to understand and creates the proper incentives to the health plan to ensure the most cost effective use of long term care services. The challenge is that while a single payment rate may work where there is a mandatory program with a single contractor, it is difficult to successfully and equitably operationalize where there may be multiple contractors or a variable risk in the enrolled voluntary population. The increased potential for selection bias thereby increases the risk that the State may overpay or underpay.

Percentage off FFS equivalent costs can be another simple, easy to understand payment structure that delivers any necessary budgeted savings to the State. The challenge becomes how a health plan can be expected to achieve such a result that provides for the appropriate incentives. Depending on the expectation and the rate structure, a savings off every payment rate may not be realistic. For example, if the State establishes separate rates for persons in a nursing home and for persons in the community, but who are at risk for institutionalization, it may not be reasonable to expect to see additional savings from those rating categories. The savings will result from a reduction of members in the nursing home rating category. In fact, the average cost in both rating categories could increase depending on the acuity of the members who are shifting from the nursing home to the community. The State will have to carefully evaluate and assess what a reasonable savings expectation would be and may need to vary the expectation depending on the rating category and the year of operation.

Transition rates are used in the Massachusetts SCO program to incent health plans to shift members out of nursing homes and keep members in the community longer. The result is an increase in the capitation payment for the Community nursing home certifiable population, since the rate includes the first 3 months of a nursing home stay.

Correspondingly, the Nursing Home rate is reduced slightly, since the rate includes the first 3 months of a community stay for those who transition back to the community. One advantage includes creating the proper incentives in the respective rating categories to encourage greater use of Community based services and delay unnecessary institutionalization since the Community population rate is potentially more profitable to a health plan than a nursing home population rate. A disadvantage is that the methodology provides a potential disincentive for health plans to enroll those currently in a nursing home so that any potential for immediate savings to the State is delayed.

Minnesota provides an incentive payment if a member is discharged back into the community from the nursing home. The advantage to this method is that there is a direct tie and reward to the policy goal of increasing community based long term care services and reducing nursing home use. The disadvantage may be the potential for gaming by the health plans, since they could move members into nursing homes for a short period of time and then return them to the community to generate the incentive payment. The other concern would be the impact to the quality of care. Some institutionalizations are necessary and the State would need to carefully monitor the rate of movement into and out of institutions to ensure that the change in setting is appropriate. Also, the incentive would need to be set appropriately to make sure that the financial incentive is not overly generous to the detriment of the individual members.

Performance targets can be easily measured and communicated as part of the contract with the health plans. For example, the contract could include the payment of an additional 1 percent above the contract rate if the ratio of community members to nursing home members increases by a certain agreed upon percentage. Again, the performance target would need to be defined prior to the beginning of the contract and the methodology for measuring the result would need to be established in advance. The targets would need to be created so as to not create the wrong incentive that could jeopardize patient care or allow the health plans to easily game the result. In addition, payments would need to be made retroactively. The state would need to determine in advance how it would potentially fund the performance targets if they were established as an incentive. If the performance targets include a penalty, the state would have to establish a mechanism to collect the funds, but may be more limited in what a reasonable penalty would be.

# 7

## **Medicare Payment Sufficiency Study**

The general sufficiency of Medicare reimbursement was examined to determine the potential risk of ALTCI health plans incurring a loss on the dual eligible population due to Medicare reimbursement. This is important because Medicare losses could ultimately result in health plans limiting their exposure to the dual eligible population and eventual participation in the ALTCI program. If the Medicare reimbursement is considered more than adequate, the Medi-Cal funding may be able to be scaled back for certain ALTCI subpopulations and directed at others. The Medicare sufficiency analysis was not performed on Part D coverage because this new coverage is being implemented with risk sharing provisions that limit health plan exposure to profits and losses.

In recent years the Medicare reimbursement has moved from demographic rates that incorporate multipliers for institutionalization or Medicaid/working status (non-institutionalized). These multipliers vary by age and gender for Part A and Part B coverage. The demographic rates have been incrementally replaced with an individual risk share that takes into account the member's age, gender, Medicare status, and the disease conditions the member incurred in the prior year to estimate the current year's risk using the CMS-Hierarchical Condition Categories (HCC) model. Medicare is continuing to refine their payment mechanisms and as such, the sufficiency of those payments cannot be adequately assessed into the future. However, for the purposes of the sufficiency analysis the CY 2005 mix levels were assumed, which is a blended rate that is comprised of 50 percent of the demographic rate and 50 percent of the CMS-HCC rate.

A key component of the Medicare sufficiency study is the risk adjusted rate for the ALTCI population. This was accomplished by calculating the individual risk scores for recipients with both Medicare Part A and Part B coverage because the requisite diagnostic experience for the CMS-HCC model was present for this population. Using the diagnoses present within the CY 1999 data, the CY 2000 base capitation rates were multiplied by

the risk score for each of the proposed dual eligible rate cells. The CY 2000 risk adjusted rate was then compared to the CY 2000 Medicare FFS costs for the same recipients with both Part A and Part B coverage. The results of this analysis indicate that Medicare payments for both Contra Costa and San Diego would have been sufficient for the ALTCI population in total.

The components of the Medicare sufficiency analysis are presented in Attachment D. A summary of the Medicare sufficiency results are presented in Attachment E, where the shaded boxes indicate the proposed rate structure.

The general findings of the historical Medicare sufficiency analysis were consistent between Contra Costa and San Diego. Both counties' results showed adequate funding in total, but Nursing Home and At Risk populations are not sufficiently funded. The Not at Risk and DD populations are more than adequately funded. As a result, the State may want to consider some reductions to the Not at Risk and DD rates to move additional funds into the Nursing Home and At Risk populations to offset some of the potential losses due to Medicare payment inadequacy for those specific populations. This type of redistribution may be useful to improve the overall (Medi-Cal and Medicare) viability of the ALTCI health plans.

## 8

### **ALTCI Financing Options**

#### **Rating Categories**

Based on the identification of the key cost drivers and the assumed goal of the State to have the same payment mechanism apply in each of the three ALTCI participating counties, it would be ideal to have a rating structure that differentiates payments based on the following variables:

- separate rate based on setting (Nursing Home, Community),
- separate rate based on frailty (At Risk, DD, and Not at Risk),
- separate Medi-Cal Only and Dual rates, and
- separate rate based on category of aid for the Community Not at Risk group.

#### **Risk Adjustment**

As an alternative to the 10 rating categories described above, Medi-Cal could implement a risk adjustment model. However, to our knowledge, no such broad-based risk adjustment model exists at the moment specifically for a Medicaid LTC program. While Medicare payments are moving toward risk adjustment, potentially benefiting contracting health plans, a separate Medi-Cal LTC risk adjustment model would need to be developed and maintained by the State based on the eligible services included in the Medi-Cal capitation payment, which for this population, differ significantly from Medicare.

Other ways to risk adjust may include a separate rating category for specifically identified high cost disease states. Our analysis indicated that there is at least one disease state that merits special consideration, those who are classified as ventilator dependent. For those ventilator dependents living in the community, while small in numbers, they are very high in cost. Mercer recommends that the State review the ventilator dependent costs separately, and consider a separate capitation rate or stop loss policy to protect the health plans from any adverse risk due to the ventilator dependents. As mentioned previously,

Arizona's ALTCS program currently has a separate rating category for ventilator dependents that is significantly higher than the payment rate for non ventilator dependent members to mitigate high cost adverse risk.

## **Risk Sharing and Reinsurance**

Since ALTCS is a new program and the characteristics of the population enrolling in each plan will be difficult to predict, the State may want to consider the implementation of a risk sharing arrangement where both the excess profits and losses are shared by the plans and the State. Risk sharing provides protection to both entities as the program enrollment rolls out and the experience is established. While risk sharing is beneficial for new programs, steps should be taken to communicate the temporary nature of the risk sharing program, so as to more easily eliminate it once the ALTCS program is established and experience becomes more stable and predictable.

Massachusetts SCO program currently has a risk sharing program where the state and health plan both share a portion of any loss or gain of medical and administrative expenditures compared to the capitation payment. For losses or gains between 0 percent and 5 percent of capitation revenue, there is no sharing. For losses and gains between 5 percent and 15 percent of capitation revenue, the additional cost/profit is shared 50 percent by the state and 50 percent by the health plan. For losses between 15 percent and 25 percent of capitation revenue, the additional cost is shared 75 percent by the state and 25 percent by the health plan. For gains between 15 percent and 25 percent of capitation revenue, the 75 percent of the additional profit is returned to the state and 25 percent is retained by the health plan. For losses in excess of 25 percent, the health plan is responsible for payment. For profits in excess of 25 percent, the health plan retains those gains. The risk sharing program is expected to terminate in 3 years.

Reinsurance programs protect a health plan from adverse risk due to a single high cost individual. Most state reinsurance programs share in costs above a certain threshold, such as claims for a person in excess of \$100,000 per year. Typically, reinsurance programs share in the costs for inpatient hospital expenses only, since these expenses are easily measured and contribute significantly to individual high cost cases. In order to ensure that the health plan continues to manage the care of a hospitalized member, costs are generally shared by both the state and the health plan, with the state picking up a larger percentage of the costs. Overall capitation payments are reduced to help fund the reinsurance costs by the state.

With both reinsurance and with risk sharing, the state needs to carefully define the expenditures that would be shared and the methodology for determining additional payments. Mercer recommends that the state consider the implementation of both a reinsurance program and a risk sharing program in the initial years of the program to protect the state and its health plan partners from any adverse risk until the ALTCS program is well established.

# 9

## **Conclusions**

There are many variables that require consideration when developing a payment mechanism that appropriately reimburses health plans for the risk of the population enrolled. Program design of who will be eligible and what services will be covered will drive the potential risk differential that can be expected among contracted health plans. Contracting approach and the number of enrollment options available to members will also be an important determinant to the potential variance in population risk among contracted health plans. In order to create the appropriate incentives of care management and service integration, reimbursement needs to be sufficiently sophisticated to promote program goals, especially in situations when multiple health plans will enroll the target populations and the ALTCI population will voluntarily enroll into health plans.

A sophisticated reimbursement strategy needs to recognize key cost drivers and consider their influence when designing the rate structure that will be the basis of the health plan's monthly compensation for the members enrolled. Based upon the data presented within the report, the key cost drivers were determined to be setting, frailty, and Medicare status. However, category of aid was determined to be a significant cost driver for the population that was Not at Risk of institutionalization. Based upon the identification of the key cost drivers and the assumed goal of the State to have the same payment mechanism apply in each of the three ALTCI participating counties, it would be ideal to have a rate structure that differentiates payments by the combination of setting, frailty, Medicare status, and category of aid (only applicable for the Not at Risk subpopulation).

Rather than implement the proposed rate structure, Medi-Cal could implement a risk adjustment model, but no such broad-based risk adjustment model exists at the moment specifically for a Medicaid LTC program. Other ways to risk adjust may include a separate rating category for specifically identified high cost disease states. Our analysis

indicated that there is at least one disease state that merits special consideration, those who are classified as ventilator dependent.

The reimbursement strategy extends beyond the rate structure itself. Certain provisions can be elected to restrict a health plans risk to unexpected catastrophic cases by offering a state-sponsored reinsurance program. The high-cost case analysis showed that most outlier cases exist from more acute types of episodes or conditions that are not easily predicted by any of the identified cost drivers. Therefore, individual stop-loss (reinsurance) coverage may well be appropriate to match reimbursement to the risk of these outliers.

In addition to the reinsurance program, the State should consider a risk sharing program for the first few years of the ALTCI program. This protects both the State and the health plans from unexpected occurrences related to new programs that could result in excess profits or losses. The risk sharing provision protects the health plans from the possible adverse risk associated with an unknown enrolled population. These types of arrangements have been proven successful in other programs by attracting the necessary health plans and provider networks by demonstrating the state's willingness to be a partner with the health plans and support the level of funding necessary to ensure that the health plans and provider networks remain viable financial partners.

Creating the proper incentives to promote community based alternatives for the nursing home certifiable membership along with the early risk sharing program helps to promote the policy and financial goals of the state. Incentives should be included to promote increased community based programs, such as those introduced in other states. The single rate and percent savings from the FFS equivalent approaches work best under a simple rate structure, which is viable because few enrollment options exist for the recipients. Due to the multiple health plan options and voluntary nature of the ALTCI program anticipated for San Diego, these approaches would not be recommended. Any of the following may be used in combination with the proposed rate structure: incentive payment for nursing home discharges, use of transitional rates, and performance targets.

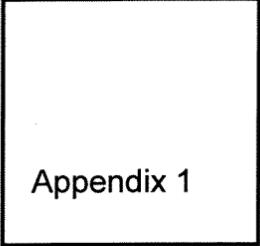
The general findings of the historical Medicare sufficiency analysis were consistent between Contra Costa and San Diego. Both counties' results showed adequate funding in total, but Nursing Home and At Risk populations are not sufficiently funded. The Not at Risk and DD populations are more than adequately funded. As a result, the State may want to consider some reductions to the Not at Risk and DD rates to move additional funds into the Nursing Home and At Risk populations to offset some of the potential losses due to Medicare payment inadequacy for those specific populations. This type of redistribution may be useful to improve the overall (Medi-Cal and Medicare) viability of the ALTCI health plans.

Case management is a critical component to the successful integration and utilization management of the integrated acute and long term care program. Strong case management has proven to improve the quality of care of the individual members and increased efficiency, thereby reducing costs overall through more appropriate use of hospital, emergency room, and nursing home services. As such increased case management should be supported and funded. However, the financial savings generated from some of the case management activities may not be readily observed in the initial years of the program.

While case management will likely produce medical savings, these services will result in some administrative costs. The reimbursement model will have to reflect the appropriate costs for administration within the capitation rate, which will include case management and other assigned activities to the health plans. In order to appropriately assess this value, the State and the counties will have to determine who will need to perform each administrative responsibility and determine how funding for administration will be accomplished. Furthermore, in the initial years of the program, health plans will need to make a significant investment in their program; incurring additional start-up costs. To ensure sufficient plan participation, the State should focus on adequate funding and health plan protections in the initial years of the program. The administrative costs as a percentage of total revenue will likely be higher in the initial years due to both start-up expenses and because the membership base will still be ramping up.

In summary, the reimbursement strategy should include the following:

- rate structure that incorporates the determined cost drivers,
- a state-sponsored reinsurance (individual stop-loss) option,
- aggregate risk sharing for profits and losses in the initial years of the program,
- some community based incentives that are consistent with the rate structure,
- considerations for the joint funding between Medicare and Medi-Cal,
- reasonable savings estimates for the first years of the program, and
- adequate administrative funding for the responsibilities assigned to the health plans.



Appendix 1

## **Managed ABD Case Studies**

## Program Design

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## Medicaid Acute

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Notes:-

- 1) AZ ALTCS and AHCCCS include state-sponsored reinsurance.
- 2) Some programs have special payment arrangements for disease specific conditions such as traumatic brain injury and Alzheimer/dementia.
- 3) AZ ALTCS has multiple healthplans in one of fifteen counties. The other fourteen counties have one contractor.
- 4) AZ ALTCS develops Acute, HCBS, and Institutional rates separately, and then blend the three for one capitation rate. Vent-dependant is paid as a separate rate.
- 5) MA SCO and PACE receive Medicare Medicaid care for dual eligibles.
- 6) First 180 days of Nursing Facility care is the MCO's responsibility.
- 7) Dual eligibles under age 21 are voluntary.
- 8) First 120 days of Nursing Facility care is the MCO's responsibility.
- 9) First 30 days of Nursing Facility care is the MCO's responsibility.

Appendix 2

## Category of Aid Definitions

The cost driver analysis presents historical and projected Medi-Cal costs separately for the Aged and Disabled populations. Below is a listing of the beneficiary aid codes that were included within the cost driver analysis by Aged and Disabled classifications:

Category of Aid	Beneficiary Aid Code and Description
Aged	10 Aged (SSI/SSP <sup>1</sup> )
	13 Aged—Long Term Care
	14 Aged—Medically Needy
	16 Aged—PICKLE Eligibility
	17 Aged—Medically Needy-Share of Cost
	18 Aged—In-Home Support Services (IHSS)
Disabled	20 Blind (SSI/SSP)
	23 Blind—Long Term Care
	24 Blind—Medically Needy
	26 Blind—PICKLE Eligibility
	27 Blind—Medically Needy-Share of Cost
	28 Blind—IHSS
	60 Disabled (SSI/SSP)
	63 Disabled—Long Term Care
	64 Disabled—Medically Needy
	65 Disabled—SGA/ABD-MN (IHSS)
	66 Disabled—PICKLE Eligibility
	67 Disabled—Medically Needy Share of Cost
	68 Disabled—IHSS
	6A Disabled—Adult Child(ren) (DAC) – Blind
	6C Disabled—Adult Child(ren) (DAC) – Disabled

<sup>1</sup> Supplemental Security Income/State Supplemental Payment (SSI/SSP)

## Appendix 3

### **Incorporated Policy Changes**

In order to project the Medi-Cal experience from CY 2000 to CY 2007, trends were applied along with known, material policy changes. In order to assess the policy changes for incorporation into the Medi-Cal projections, the Medi-Cal Policy Division published reports titled “PACE Upper Payment Limits for Periods Beginning Between October 1, 2001 and September 30, 2002” and “Two Plan Model Preliminary Capitation Rates for October 1, 2002 through September 30, 2003” were reviewed for significance. The result was the application of the following significant policy changes in the development of the Medi-Cal projections presented within this report:

1. Sunset of Transitional Inpatient Care (#113) — After January 1, 2002, legislative authorization sunset and TIC is no longer available. This will increase Hospital Inpatient utilization by about 2.5 percent.
2. EDS Cost Containment Projects (#91) — FY2001/2002 budget proposals that remove approximately 1 percent of utilization from all vendor types except Pharmacy and Long Term Care.
3. FY2000/2001 Anti Fraud Expansion (#100) — Based on additional staffing, the Department expanded its anti-fraud activities. These activities will result in approximately 6 percent savings to all aid codes in Physician, Pharmacy, Hospital Outpatient, and Other services. Because this adjustment was implemented in the middle of CY2000, only half of this utilization adjustment has been applied.
4. Drug Budget Reduction (#73) — The FY2002/2003 budget included a number of special adjustments that were made to the rules regarding the use of pharmaceuticals. There is a utilization reduction of almost 10 percent in Pharmacy for all aid code groupings.

5. Nursing Facility Staffing Ratio Increase (#27) — The May 2000 legislative estimate included an increase in Medi-Cal staffing ratio of nursing hours to patients per day in Nursing Facilities from 2.92 to 3.2. This increases the Long Term Care unit cost by 3.6 percent.
6. Provider Rate Reduction (#98) — FY 2002/2003 proposed provider rate reductions which are generally targeted to the adult population. The result of these reductions will be savings to Physician of approximately 13 percent in all aid groupings. The
7. Orthopedic Hospital Settlement (#69) — Pending federal approval, the administration has settled this lawsuit. As a result, the FY2001/2002 budget included an increase Hospital Outpatient by 30 percent.
8. Orthopedic Hospital Settlement (#73) — The Administration has settled the lawsuits related to the amount Medi-Cal pays for Hospital Outpatient services. This represents the second increase (FY2002/2003 budget), which is in the amount of 3.3 percent to all aid code groupings.

The manuals used to develop the above policy change listing did not include any changes relative to personal care services. Between CY 2000 and CY 2007, the contracting arrangement with personal care service providers changed, which resulted in a substantial rate increase. Using the monthly data provided by the Contra Costa IHSS Public Authority and San Diego Aging & Independence Services, the contracting service change was estimated as a 23.2 percent increase. All other increases were incorporated within the trend factors.

In anticipation of the Medicare Part D implementation, where Medi-Cal will only be responsible for a minor portion of the pharmacy benefit (primarily over the counter medications and a few specialty drugs) for recipients with both Medicare and Medi-Cal coverage (dual eligibles). To reflect this upcoming program change in the analysis, pharmacy expenditures for dual eligibles were reduced by 93 percent. While the Medicare Part D coverage is fairly comprehensive, some pharmaceuticals will remain Medi-Cal's responsibility.

Several fee schedule increases and budget increases due to the introduction of new drugs have been implemented over the years. These types of budget changes were accounted for in the development of the trend factors.

Appendix 4

**Chronic Disease Condition Analysis**

**Appendix 4.1**  
**Chronic Condition Analysis**  
**CY 1998-CY 2000 Experience for Alameda, Contra Costa, and San Diego**  
**All Cases**

Disease	AT RISK (1)				NOT AT RISK (2)				COMBINED (3)			
	MMs	Dollars	PMPM	Rank	MMs	Dollars	PMPM	Rank	MMs	Dollars	PMPM	Rank
Vent Dependent	7,530	\$ 22,424,935	\$ 2,978	1	13,624	\$ 8,514,034	\$ 625	1	21,154	\$ 30,938,969	\$ 1,463	1
AIDS/HIV	23,744	\$ 36,389,125	\$ 1,533	2	56,017	\$ 34,595,202	\$ 618	4	79,761	\$ 70,984,327	\$ 890	2
Traumatic Brain Injury	4,068	\$ 5,030,820	\$ 1,237	5	7,702	\$ 4,760,511	\$ 618	3	11,770	\$ 9,791,331	\$ 832	3
Developmental Disability (5)	6,255	\$ 8,206,249	\$ 1,312	3	9,106	\$ 3,402,927	\$ 374	5	15,361	\$ 11,609,176	\$ 756	4
Medical Disability (7)	8,678	\$ 11,158,704	\$ 1,286	4	65,018	\$ 40,223,676	\$ 619	2	73,696	\$ 51,382,381	\$ 697	5
Alzheimer's/Dementia	56,203	\$ 57,318,801	\$ 1,020	7	55,239	\$ 14,250,963	\$ 258	10	111,442	\$ 71,569,763	\$ 642	6
Cerebro-vascular Disease	114,171	\$ 99,240,271	\$ 869	11	177,286	\$ 58,558,057	\$ 330	6	291,457	\$ 157,798,328	\$ 541	7
Congestive Heart Failure	90,146	\$ 74,402,320	\$ 825	12	171,832	\$ 55,731,716	\$ 324	7	261,978	\$ 130,134,036	\$ 497	8
Neurological Disability (6)	6,770	\$ 7,369,898	\$ 1,089	6	24,708	\$ 6,490,695	\$ 263	8	31,478	\$ 13,860,592	\$ 440	9
Parkinson's Disease	10,817	\$ 8,525,467	\$ 788	13	15,243	\$ 2,407,915	\$ 158	17	26,060	\$ 10,933,382	\$ 420	10
Mental Retardation	2,955	\$ 2,806,922	\$ 950	9	9,797	\$ 1,804,695	\$ 184	12	12,752	\$ 4,611,617	\$ 362	11
Alcohol/Substance Abuse	2,941	\$ 2,571,691	\$ 874	10	27,644	\$ 7,203,991	\$ 261	9	30,585	\$ 9,775,682	\$ 320	12
Psychosis	11,258	\$ 8,668,985	\$ 770	14	73,390	\$ 15,493,855	\$ 211	11	84,648	\$ 24,162,840	\$ 285	13
Physical Disability (8)	23,717	\$ 22,837,126	\$ 963	8	134,297	\$ 17,989,179	\$ 134	21	158,014	\$ 40,826,305	\$ 258	14
Chronic Heart Disease	91,138	\$ 58,023,289	\$ 637	19	369,523	\$ 64,449,987	\$ 165	13	480,661	\$ 122,473,276	\$ 255	15
Diabetes	59,336	\$ 41,294,293	\$ 686	15	317,587	\$ 52,141,721	\$ 164	14	376,923	\$ 93,436,014	\$ 248	16
COPD/Asthma/Emphysema	39,776	\$ 26,937,853	\$ 677	16	238,376	\$ 38,332,961	\$ 161	15	278,152	\$ 65,270,814	\$ 235	17
Depression	42,505	\$ 26,116,912	\$ 614	20	278,262	\$ 37,963,879	\$ 136	20	320,767	\$ 64,080,790	\$ 200	18
CMI Disability (4)	2,131	\$ 1,377,651	\$ 646	18	23,975	\$ 3,817,589	\$ 159	16	26,106	\$ 5,195,239	\$ 199	19
OTHER	9,896	\$ 6,563,402	\$ 663	17	116,833	\$ 17,752,905	\$ 152	19	126,729	\$ 24,316,307	\$ 192	20
Schizophrenia	6,899	\$ 4,118,621	\$ 597	21	84,247	\$ 12,977,266	\$ 154	18	91,146	\$ 17,095,887	\$ 188	21
Arthritis	40,080	\$ 23,251,698	\$ 580	22	199,568	\$ 18,843,428	\$ 94	22	239,648	\$ 42,095,126	\$ 176	22
Sensory Disability (9)	6,726	\$ 3,576,071	\$ 532	24	96,080	\$ 7,353,062	\$ 77	23	102,806	\$ 10,929,132	\$ 106	23
NONE	71,209	\$ 39,593,876	\$ 556	23	1,232,524	\$ 61,545,977	\$ 50	24	1,303,733	\$ 101,139,853	\$ 78	24
<b>Grand Total</b>	<b>738,949</b>	<b>\$ 597,804,961</b>	<b>\$ 809</b>	<b>24</b>	<b>3,817,878</b>	<b>\$ 586,606,189</b>	<b>\$ 154</b>	<b>24</b>	<b>4,556,827</b>	<b>\$ 1,184,411,170</b>	<b>\$ 260</b>	<b>24</b>

- (1) The AT RISK category contains MSSP, IHSS and Home Care recipients.
- (2) The NOT AT RISK category contains only Community recipients.
- (3) Includes the At Risk and Not At Risk populations; excludes the Nursing Home and DD populations.
- (4) Includes alcoholic, drug, schizophrenic, and affective psychoses along with neurotic and personality disorders.
- (5) Includes mental retardation, infantile cerebral palsy, muscular dystrophies, and Spina bifida.
- (6) Includes multiple sclerosis, Epilepsy, and disorders of the autonomic nervous systems.
- (7) Includes Hodgkin's disease and hereditary hemolytic anemias.
- (8) Includes intervertebral disc disorders and diffuse diseases of connective tissue.
- (9) Includes blind, low vision, and hearing loss.

Appendix 4.2  
Chronic Condition Analysis  
CY 1998-CY 2000 Experience for Alameda, Contra Costa, and San Diego  
High Cost Cases (Medi-Cal Expenditures Greater Than \$100,000)

Disease	AT RISK (1)				NOT AT RISK (2)				COMBINED (3)			
	MMs	Dollars	PMPM	Rank	MMs	Dollars	PMPM	Rank	MMs	Dollars	PMPM	Rank
CMI Disability (4)	-	\$ -	\$ -	23	18	\$ 396,201	\$ 22,011	4	18	\$ 396,201	\$ 22,011	1
Neurological Disability (6)	26	\$ 314,791	\$ 12,107	7	54	\$ 1,332,959	\$ 24,684	3	80	\$ 1,647,750	\$ 20,597	2
Developmental Disability (5)	36	\$ 426,365	\$ 11,843	9	64	\$ 1,298,319	\$ 20,286	6	100	\$ 1,724,685	\$ 17,247	3
NONE	40	\$ 446,463	\$ 11,162	15	356	\$ 6,291,789	\$ 17,674	8	396	\$ 6,738,251	\$ 17,016	4
Mental Retardation	13	\$ 186,915	\$ 14,378	2	1	\$ 37,179	\$ 37,179	1	14	\$ 224,094	\$ 16,007	5
Physical Disability (8)	87	\$ 1,161,903	\$ 13,355	5	87	\$ 1,586,348	\$ 18,234	7	174	\$ 2,748,251	\$ 15,795	6
COPD/Asthma/Emphysema	80	\$ 903,590	\$ 11,295	13	59	\$ 1,268,979	\$ 21,508	5	139	\$ 2,172,569	\$ 15,630	7
Parkinson's Disease	9	\$ 121,575	\$ 13,508	4	1	\$ 28,661	\$ 28,661	2	10	\$ 150,236	\$ 15,024	8
Cerebro-vascular Disease	254	\$ 2,897,261	\$ 11,407	11	328	\$ 5,322,031	\$ 16,226	10	582	\$ 8,219,292	\$ 14,122	9
Vent Dependent	1,017	\$ 14,163,167	\$ 13,926	3	107	\$ 1,231,967	\$ 11,514	19	1,124	\$ 15,395,133	\$ 13,697	10
Traumatic Brain Injury	34	\$ 297,034	\$ 8,736	20	53	\$ 880,123	\$ 16,606	9	87	\$ 1,177,157	\$ 13,531	11
OTHER	41	\$ 460,208	\$ 11,225	14	88	\$ 1,265,755	\$ 14,384	11	129	\$ 1,725,963	\$ 13,380	12
Depression	95	\$ 1,195,493	\$ 12,584	6	67	\$ 922,021	\$ 13,762	13	162	\$ 2,117,514	\$ 13,071	13
Diabetes	58	\$ 621,962	\$ 10,723	16	102	\$ 1,444,194	\$ 14,159	12	160	\$ 2,066,156	\$ 12,913	14
Sensory Disability (9)	9	\$ 102,455	\$ 11,384	12	12	\$ 155,149	\$ 12,929	15	21	\$ 257,604	\$ 12,267	15
Chronic Heart Disease	102	\$ 1,214,925	\$ 11,911	8	199	\$ 2,450,505	\$ 12,314	18	301	\$ 3,665,430	\$ 12,178	16
Alzheimer's/Dementia	37	\$ 391,445	\$ 10,580	17	110	\$ 1,377,643	\$ 12,524	16	147	\$ 1,769,088	\$ 12,035	17
Congestive Heart Failure	265	\$ 2,761,153	\$ 10,419	18	302	\$ 3,922,434	\$ 12,988	14	567	\$ 6,683,587	\$ 11,788	18
Medical Disability (7)	50	\$ 477,918	\$ 9,558	19	191	\$ 2,353,975	\$ 12,324	17	241	\$ 2,831,893	\$ 11,751	19
Psychosis	7	\$ 215,840	\$ 30,834	1	34	\$ 228,188	\$ 6,711	22	41	\$ 444,028	\$ 10,830	20
Schizophrenia	-	\$ -	\$ -	23	29	\$ 300,820	\$ 10,373	20	29	\$ 300,820	\$ 10,373	21
Arthritis	36	\$ 425,582	\$ 11,822	10	56	\$ 416,327	\$ 7,434	21	92	\$ 841,909	\$ 9,151	22
Alcohol/Substance Abuse	11	\$ 93,098	\$ 8,463	21	24	\$ 109,133	\$ 4,547	24	35	\$ 202,231	\$ 5,778	23
AIDS/HIV	562	\$ 3,120,401	\$ 5,552	22	401	\$ 2,367,530	\$ 5,904	23	963	\$ 5,487,931	\$ 5,699	24
Grand Total	2,869	\$ 31,999,543	\$ 11,154	24	2,743	\$ 36,988,232	\$ 13,485	24	5,612	\$ 68,987,775	\$ 12,293	24

- (1) The AT RISK category contains MSSP, IHSS and Home Care recipients.
- (2) The NOT AT RISK category contains only Community recipients.
- (3) Includes the AT Risk and Not At Risk populations; excludes the Nursing Home and DD populations.
- (4) Includes alcoholic, drug, schizophrenic, and affective psychoses along with neurotic and personality disorders.
- (5) Includes mental retardation, infantile cerebral palsy, muscular dystrophies, and Spina bifida.
- (6) Includes multiple sclerosis, Epilepsy, and disorders of the autonomic nervous systems.
- (7) Includes Hodgkin's disease and hereditary hemolytic anemias.
- (8) Includes intervertebral disc disorders and diffuse diseases of connective tissue.
- (9) Includes blind, low vision, and hearing loss.